



Welcome

Neuropsychological services for CALD clients



Neuropsychology for CALD clients

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Can
Culture & Language
change the way we
THINK?

It's hard for me to sit and read – I have to focus more than other people.



Am I stupid?





Cultural Norms

Common beliefs, expectations, and practices shared between groups

→ may have conferred adaptive advantages by facilitating efficient coordination of activities necessary for survival, sexual reproduction, and the successful rearing of children to mating age.

Consequently, several theoretical analyses suggest that

culture emerged as an extraordinary and highly flexible sort of evolutionary adaptation
(Barkow et al. 1992)

Cultural Norms

Culture represents an inescapably fundamental element in individuals' physical and social environments, and so —through the mechanisms of cultural learning— has enduring consequences on individuals' thoughts, feelings, and behaviours.

(Boesch & Tomasello 1998, Carpenter et al. 1998, Fiske 2000)

Interesting?

[Chiu \(1972\)](#) examined cultural differences in categorization patterns between American and Chinese children.

In his study, children were asked to group any two of three items that "belonged together," for example, a man, a woman, and a baby.

The results indicated that Chinese children were more "relational-contextual" in their groupings, for example, grouping together a mother and a baby "because the mother takes care of the baby."

In contrast, American children were much more likely to group objects on a "categorical" basis, for example, grouping the man and the woman together "because they are both adults."

Interesting!

[Witkin and Berry \(1975\)](#) maintained that some societies require analysing the visual field in such a way as to avoid being thrown off by external cues.

Hunters and herders must analyse the features of novel information independent of context, whereas agriculturists can generally afford to merely scan the environment as a whole.



Interesting!

Consistent with this logic, Witkin and Berry found that nonliterate hunters and herders have a more analytic or "field independent" style than do nonliterate farmers, performing better on the embedded figures test that requires ignoring the details of a complex stimulus figure and finding a smaller pattern "embedded" in it.

Witkin and Berry also maintained that people who live in modern economies must be capable of substantial field independence.

They found that modern Westerners are less field dependent than agriculturists and about as field dependent as hunters and herders.

Interesting!

Hard wired?

Different regions of brain activated as measured by fMRI between Japanese and Caucasian observation of facial expressions of fear (Moriguchi et al, 2005)

WHAT'S ON

1. Understand the definition of "intelligence" from different cultures
2. Understand the effects of culture and education on neuropsychological testing
3. Identify factors that impact on neuropsychological assessment for Indigenous clients
4. Understand the effects of trauma and refugee experience on psychological and neuropsychological presentation
5. Utilise cognitive impairment screening tools for CALD clients
6. Utilise the Cultural Formulation Interview (CFI) from DSM-5

Definition of “intelligence” from different cultures

Intelligence

inˈtɛlɪdʒ(ə)n(s)/
noun

1. the ability to acquire and apply knowledge and skills.



Definition of “intelligence” from different cultures

WHAT IS YOUR DEFINITION?

A PERSON IS INTELLIGENT WHEN THEY SHOW/ DEMONSTRATE.....

(Or describe three examples or situations)

Definition of “intelligence” from different cultures

Western

Western countries tend to view intelligence as a means for individuals to devise categories and to engage in rational debate

For example, at the mental level, there is an emphasis on speed of mental processing (Sternberg 1981)

East Asian

Eastern cultures see intelligence as a way for members of community to recognize contradiction and complexity and to play their social roles successfully

So in contrast, people in Eastern countries may be suspicious of the quality of work done very quickly and emphasise depth rather than speed.

Richard Nisbett, The Geography of Thought.

Definition of “intelligence” from different cultures

Western

American people's conceptualisations of intelligence have mostly mental attributions, such as: practical problem solving and verbal ability (Sternberg 1981).

East Asian

Chen (1994) found three factors underlying Chinese conceptualisations of intelligence: nonverbal reasoning ability, verbal reasoning ability and memory.

Richard Nisbett, The Geography of Thought.

Definition of “intelligence” from different cultures

African

Serpell (1974, 1977, and 1982) found that people in Zambia emphasize social responsibilities, cooperativeness, and obedience as important to intelligence; intelligent children are expected to be respectful of adults.

In Zimbabwe, the word intelligence means to be prudent and cautious, especially in social relationships (Dasen 1984).



Definition of “intelligence” from different cultures

What is relevant, and worth learning for an Amazonian Indian, does not necessarily coincide with what is relevant and worth learning for an inhabitant of New York or Islamabad.

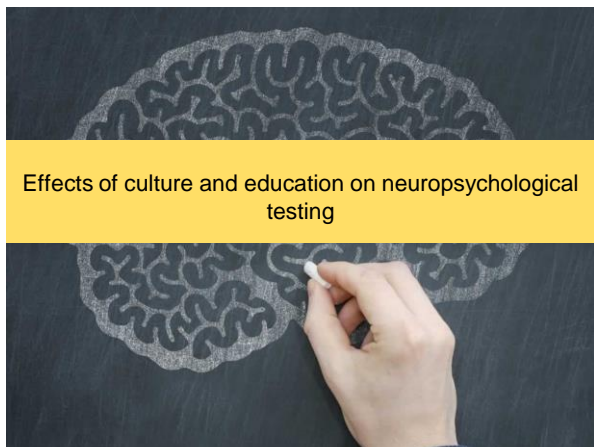
[Ardila, 1996, p. 239]

There are many ways to be intelligent . . .

Standardised tests do not sample all forms of intelligence.

[Neisser et al., 1996, pp. 95,97]

Effects of culture and education on neuropsychological testing



Effects of culture and education on neuropsychological testing

- In general, studies have reliably demonstrated poorer performance among ethnic minorities when compared to Caucasians.
- **...including significantly lower performance on tasks of nonverbal abilities**
(Bernard, 1989; Campbell et al., 1996; Heverly, Isaac, & Hynd, 1986; Miller, Bing, Selnes, Wesch, & Becker, 1993)
- Some studies have shown that these differences persist despite statistically controlling or matching for highest level of educational attainment
(Antioia iFortuny, Heaton, & Hermosillo, 1998; Jacobs et al., 1997).

Effects of culture and education on neuropsychological testing

- Australian controls of CALD background performed lower than those of English-speaking background on WAIS-R Performance IQ and WAIS-R Picture Completion subtest, but not on WMS-R measures (Carstairs, Myers, Shores, & Fogarty, 2006).
- In the same study, CALD individuals with a first language other than English also scored lower on WAIS-R Vocabulary and Verbal IQ than people whose first language was English (Carstairs et al., 2006).
- New Zealand Maori subjects performed lower on some WAIS-R and WMS-R measures than their white counterparts (Ogden, Cooper, & Dudley, 2003).

Effects of culture and education on neuropsychological testing

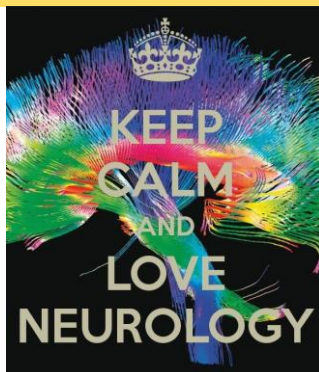
Differences among groups do in fact exist, but they can be explained by a number of factors including:

- Quality of education
- Acculturation
- Literacy
- Test-wiseness
- Racial socialization (e.g., stereotype threat)
- *Language structure*

Socioeconomic status may interact with race to influence brain development or functioning because those of lower socioeconomic class may have poorer nutrition and access to health care.

Mental Control: WMS-IV

1. Get into pairs: Person A and Person B
2. Person A: Prepare stopwatch, then ask Person B to **say the months backwards as fast as you can**, with no errors.
3. Person A: Time them!
4. Swap!



Mental Control: WMS-IV

In ENGLISH:

December, November, October, September, August, July, June, May, April, March, February, January.

If you didn't know....and you asked a MANDARIN speaking person to say the months backwards in their language....

In MANDARIN (translated to English):

12 month, 11 month, 10 month, 9 month, 8 month, 7 month, 6 month, 5 month, 4 month, 3 month, 2 month, 1 month.

Dr Alexandra J. Walker , Jennifer Batchelor , E. Arthur Shores & Mike Jones (2010)
Effects of cultural background on WAIS-III and WMS-III performances after moderate-severe traumatic brain injury, Australian Psychologist, 45:2, 112-122.

This study explored the effects of diverse cultural background and non-Western educational background on Wechsler Adult Intelligence Scale-Third edition (WAIS-III) and Wechsler Memory Scale-Third Edition (WMS-III) performances in moderate-severe traumatic brain injury within an outpatient rehabilitation setting.

Participants were aged 16-65 years and met careful selection criteria. Cultural backgrounds included people of Asian, European, Middle Eastern, African and Oceania origin.



Dr Alexandra J. Walker , Jennifer Batchelor , E. Arthur Shores & Mike Jones (2010)
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CALD-EE group obtained lower scores than the ESB group on the WAIS-III composite measure VIQ and WAIS-III subtests Vocabulary and Similarities;

CALD-NE group, some of whom were assessed with interpreter assistance, obtained lower scores than the ESB group on almost half of the measures used. Significantly lower scores were returned on WAIS-III composite measures PIQ and POI, WAIS-III subtests Picture Completion, Block Design and Similarities subtests and WMS-III Logical Memory I subtest. Effect sizes were large.

The CALD-NE group returned significantly lower scores than the CALD-EE group on WAIS-III PIQ, POI, Picture Completion and Block Design.

Dr Alexandra J. Walker , Jennifer Batchelor , E. Arthur Shores & Mike Jones (2010)
Effects of cultural background on WAIS-III and WMS-III performances after moderate-severe traumatic brain injury, Australian Psychologist, 45:2, 112-122.

Cultural factors should be considered in interpreting verbal WAIS-III results in CALD-EE individuals after moderate-severe TBI.

After moderate-severe TBI, the capacities of CALD-NE individuals, particularly those with limited English proficiency, are likely to be underestimated on some WAIS-III and WMS-III measures, and individuals may be falsely misclassified as impaired unless caution is applied to test interpretation.



SUMMARY

Culture and Language can affect the way an individual presents (intellectually, psychologically, socially etc)

Remember to ask yourself:

- Does the word/information/meaning translate accurately?
- Is this important in their culture/environment/setting?
- Could their apparent "thinking difficulty" be better explained by culture, language differences or circumstance?

A "lower than average" cognitive profile does not necessarily mean poorer cognitive function

Neuropsychologists and professionals should take into account functional presentation and other evidence of skill (e.g. speed of learning a second language)



Compared to non-indigenous Australians, Indigenous Australians:

- Head trauma accounts for 30% of injuries requiring hospitalisation in Aboriginal and Torres Strait Islander Australians (ATSI) (Helps & Harrison, 2006) compared to 18% in the general population (Tovell, McKenna, Bradley, & Pointer, 2012).
- Between 2005-2008, ATSI Australians were 21 times more likely to suffer a head injury due to assault than their mainstream counterparts (Jamieson et al., 2008).
- ATSI Australians are also 1.5 times more likely to drink alcohol at risky levels (Australian Institute of Health and Welfare, 2011), and rates of risky-drinking and alcohol-related head trauma appear to be much higher than this in some regions, such as the Northern Territory (Jayaraj et al., 2012).
- Hospital admission rate for stroke among ATSI Australians is approximately 1.5 times greater than for the general population (Thrift & Hayman, 2007).

Compared to non-indigenous Australians, Indigenous Australians:

The incidence rate of stroke for ATSI Australians has been found to be 2.6 times higher for men and 3.0 for women (Australian Institute of Health and Welfare, 2008; Katzenellenbogen et al. 2010).

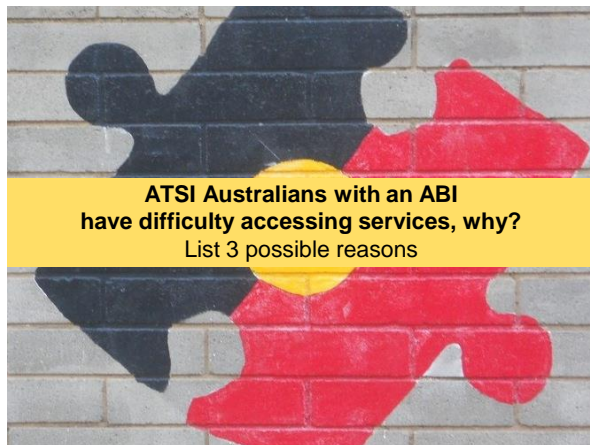
60% of Aboriginal and Torres Strait Islander non-fatal stroke burden occurring in the 25-54 year age-group compared to 24% in the non-Aboriginal and Torres Strait Islander group (Katzenellenbogen et al., 2010).

"Injuries can cause long-term disadvantage for Aboriginal and Torres Strait Islander peoples including: loss of cultural knowledge and wisdom....and continuation of the cycle of grief among families, friends and communities"

The Aboriginal and Torres Strait Islander Health Performance Framework 2010 Report (Australian Health Ministers' Advisory Council, 2011)

Compared to non-indigenous Australians, Indigenous Australians:

- Aboriginal and Torres Strait Islander Australians with cognitive impairment (including an ABI) are over-represented in criminal justice settings across Australia (Sotiri et al., 2012).
- Aboriginal and Torres Strait Islander people with a cognitive impairment (compared to the non-disabled population) are more likely to come to the attention of police, more likely to be charged, and are more likely to be imprisoned (Sotiri et al., 2012).



ATSI Australians with an ABI have difficulty accessing services

- Systemic non-supports
- Different notions of health and disability
- Lack of culturally acceptable and validated assessment instruments
- Discrimination and stigmatisation
- Lack of services in rural and remote locations

Assessment of acquired brain injury in Aboriginal and Torres Strait Islander Australians: Guidance for DisabilityCare Australia, James Cook University, The Cairns Institute, Cairns, 2013

ATSI Australians with an ABI have difficulty accessing services

Systemic non-supports

The existing disability support system in Australia has been described as a 'market failure' for Aboriginal and Torres Strait Islanders with a disability and their families, resulting in **severe personal and systemic disempowerment** (First Peoples Disability Network, 2013).

As a result, Aboriginal and Torres Strait Islander people are less likely to engage with non-Indigenous services if they perceive or experience the service as lacking cultural competency.

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ATSI Australians with an ABI have difficulty accessing services

Systemic non-supports

Aboriginal and Torres Strait Islander Australians who want to engage with the disability system may be **unaware of their rights or entitlements to receive supports, or of the necessary requirements** (such as paper work and personal information)



Australian Government Productivity Commission, 2011

ATSI Australians with an ABI have difficulty accessing services

Systemic non-supports

There are very few Aboriginal and Torres Strait Islander specific disability services, and no such services exist in many communities (First Peoples Disability Network, 2013).

Lack of ABI specific services and trained service providers may contribute to ABI going undetected or misdiagnosed.

Poor training of staff may contribute to low identification of ABI, as symptoms may be misinterpreted or obscured by competing co-morbidities (NSW Agency for Clinical Innovation, 2011).

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ATSI Australians with an ABI have difficulty accessing services

Different notions of health and disability

Aboriginal and Torres Strait Islander concepts of 'health' differ from a Western view, and **the concept of disability is a Western idea** (Sotiri et al., 2012).

Aboriginal and Torres Strait Islander people often view health in a broad sense, that includes consideration of the physical, cultural and spiritual components of wellbeing (Drew et al., 2010).

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ATSI Australians with an ABI have difficulty accessing services

Different notions of health and disability

These perceptions can influence:

- an individual's attitude to their own health status
- when and why people access services
- acceptance or rejection of treatment
- likelihood of continuing to follow treatment recommendations
- likely success of prevention and health promotion strategies

Australian Health Ministers' Advisory Council, 2004

ATSI Australians with an ABI have difficulty accessing services

Lack of culturally acceptable and validated assessment instruments

- Inability to assess with reliable and valid measures can result in further disadvantage
- Impairments may go undetected, undiagnosed and untreated
- National consultations by Brain Injury Australia (2012) reported widespread concerns about the assessment, management and outcomes of brain injury in Aboriginal and Torres Strait Islander communities and individuals.

Dingwall & Cairney, 2009

ATSI Australians with an ABI have difficulty accessing services

Discrimination and Stigmatisation

Also consider “**structural racism**” - lack of cultural knowledge and sensitivity result in processes that are incompatible with Aboriginal and Torres Strait Islander cultural approaches and values (First Peoples Disability Network, 2013).

Lack of services in rural and remote locations

In 2006, 24% of Aboriginal and Torres Strait Islander Australians lived in remote or very remote areas, compared to around 1% of the general population (Australian Government Productivity Commission, 2011).

Reliance on the 'fly in/fly out' 'outsider' service delivery where the development of trust and engagement is difficult (NSW Agency for Clinical Innovation, 2011).

+ Skills shortage

ATSI Australians with an ABI have difficulty accessing services

BREAKING DOWN BARRIERS

1. Engage through the community's preferred and/or nominated channels
2. Know as much as possible before proceeding with engagement (e.g. physical, social, historical, cultural and political context in which engagement is to occur)
3. Clearly communicate the assessment process to ensure prospective participants understand their involvement and the potential outcomes
4. Allow time for people to think about ideas and proposals and to discuss them informally amongst themselves in their own language

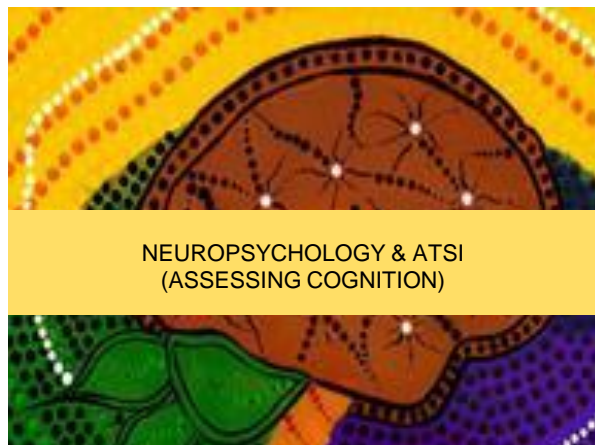
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ATSI Australians with an ABI have difficulty accessing services

BREAKING DOWN BARRIERS

5. Ensure engagement activity is outcomes focused, not just a box to be ticked
6. Successful outcomes need to demonstrate how the relationship has been improved through the engagement
7. Communicate to the family how the ascertained level of support is to be managed and administered
8. Feedback should be provided through the appropriate channels

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Assessment of Cognition and ATSI Australians

In non-Indigenous cultures it may be perfectly normal for a man to speak the name of a deceased relative or to talk to his mother in law, but in Indigenous Australian cultures such behaviours may be considered mad because they violate strict cultural rules and norms [11,20,21].

Psychiatric disorders may also be expressed through different symptomatology. For example, anger may represent a culturally specific symptom of depression for Indigenous Australians

an Indigenous child from a particular desert community might instead be expected to know directions, space and place or demonstrate independence to be considered intelligent

Quick interesting fact

Published early work with children in Indigenous communities by Kearins (1986), showed that Indigenous children, whether of traditional or non-traditional background, showed greater strengths on visuospatial tasks than non-Indigenous children.

Neuropsychology and ATSI

According to DisabilityCare Australia, 4 instruments were found that had been developed specifically for assessing cognition in Aboriginal Australians:

- Kimberley Indigenous Cognitive Assessment (KICA)
- Cognitive Assessment for Aboriginal People
- Q Test
- CogState Assessment Battery



...For Dementia: Rowland Universal Dementia Assessment Scale (RUDAS)

Neuropsychology and ATSI

Kimberley Indigenous Cognitive Assessment (KICA)

- Generally used for Aboriginal clients of all ages
- But validated only for use with Aboriginal people aged ≥ 45 years

Cognitive Assessment for Aboriginal People

- Never been validated, thus cannot be used reliably to assess cognition

Q Test

- Been validated
- But recent normative data are not readily available (Drew et al., 2010, p. 195)

CogState Assessment Battery

- Some demonstration of reliability in adolescent Aboriginal Australians (Dingwall, Lewis, Maruff, & Cairney, 2009)
- Never been validated for the assessment of cognitive impairment or in adult Aboriginal or Torres Strait Islander Australians.

Neuropsychology and ATSI

Other readily accessible assessments to use:

Sydney Psychosocial Reintegration Scale

- Assesses three functions of individuals after suffering a Traumatic Brain Injury, occupational skills, living skills and interpersonal relations

Overt Behaviour Scale

- Designed to measure the frequency, severity and impact of challenging behaviours as a result of ABI in patients aged >16
- Behaviours are assessed through direct observation or interview with informant such as spouse or case manager
- The behaviours are placed in 9 categories, verbal aggression, physical aggression against objects, physical acts against self, physical aggression against other people, inappropriate sexual behaviour, perseveration / repetitive behaviour, wandering / absconding, inappropriate social behaviour, lack of initiation.



Effects of trauma and refugee experience on psychological and neuropsychological presentation



Effects of trauma and refugee experience on psychological and neuropsychological presentation

The Annual Report of the Victorian Foundation of Survivors of Torture (VFST, 2007a) indicated that the under-18-year-old client group had experienced a high degree of physical and psychological trauma:

- 44% experiencing combatant fire,
- 33% experiencing severe beatings,
- 78% experiencing war-related loss and separation,
- 94% having experienced harm to their family.

The frequency of harm and threatened harm are very high.

Such experiences are compounded by a range of pre-arrival hardships that include poor nutrition, inadequate shelter, lack of access to health services and disruptions to schooling.

Dr I. Kaplan, Foundation House

Effects of trauma and refugee experience on psychological and neuropsychological presentation

Once in Australia...

Ongoing grief associated with separation from family and community

Guilt about family remaining in difficult circumstances overseas

Material circumstances are typically difficult due to unemployment or under-employment and the high cost of housing and utilities.

Learning a new language, adjusting to a new culture and dealing with the practical tasks of establishing life in a new country, can also contribute to stress.

Social support networks can be limited because of the small size of refugee communities and fragmentation within those communities.

Retraumatizing: exposure to racist and xenophobic behaviour

Dr I. Kaplan, Foundation House

Effects of trauma and refugee experience on psychological and neuropsychological presentation

Older, unattached refugees with less proficiency in English are at increased risk for depression (Hinton et al., 1997)

The stigma associated with mental illness often pushes family members to "hide" the problems of the impaired family member (Shiang et al., 1998).

The neuropsychologist is challenged to differentiate the significant overlap of symptoms associated with traumatic brain injury (TBI), depression, stress, and posttraumatic stress disorder (PTSD).

The common symptoms of TBI, including memory and attentional deficits (Gasquoine, 1997), and apathy, labile affect, impaired social judgment, distractibility, and impulsivity (Dikmen et al., 1996) may easily be labelled as PTSD, and it is possible that in a subgroup of torture survivors, psychiatric symptoms are primarily due to TBI alone, and are exacerbated by stressor severity.

Effects of trauma and refugee experience on psychological and neuropsychological presentation

Clarification of Diagnostic Issues

1. Review patient records
2. Obtain detailed medical and psychological history
3. Seek corroborating data about type of injury/length of LOC
4. Identify complicating medical contributors to behaviour (alcohol and smoking leading to asthma and sexual dysfunction; Bieliauskas and Turner, 2000)
5. Complete neurobehavioral symptom checklist

Weinstein, C. S., Fucetola, R., & Mollica, R. (2001). Neuropsychological issues in the assessment of refugees and victims of mass violence. *Neuropsychology Review*, 11(3), 131-41. doi:http://dx.doi.org/10.1023/A:1016650623996

Effects of trauma and refugee experience on psychological and neuropsychological presentation

Clarification of Diagnostic Issues

6. Interview family with focus on current and premorbid personality and cognitive functioning
7. Document family reports of intellectual changes
8. Assess arousal problems (e.g., hypoarousal, reduced alcohol tolerance, and noise intolerance; Nell, 2000)
9. Assess reports of personality change (e.g., increased aggressiveness, irritability, apathy, changes in tact and social appropriateness, decreased personal hygiene, fear, and risk taking; Nell, 2000)
10. Establish baseline of cognitive functions with culture-fair measures

Weinstein, C. S., Fucetola, R., & Mollica, R. (2001). Neuropsychological issues in the assessment of refugees and victims of mass violence. *Neuropsychology Review*, 11(3), 131-41. doi:http://dx.doi.org/10.1023/A:1016650623996

Effects of trauma and refugee experience on psychological and neuropsychological presentation

Clarification of Diagnostic Issues

11. Evaluate inconsistencies in current performance (e.g., loss of set, perseverative behaviour, intrusions, impaired handwriting, and motoric anomalies)
12. Delineate types of cognitive impairment that are less likely to be observed in primary depression (e.g., severe visual-spatial deficits, failure to learn with drilling, and language impairment that represents a change; Veiel, 1997; King and Caine, 1996; Rosenstein, 1999)

Weinstein, C. S., Fucetola, R., & Mollica, R. (2001). Neuropsychological issues in the assessment of refugees and victims of mass violence. *Neuropsychology Review*, 11(3), 131-41. doi:<http://dx.doi.org/10.1023/A:1016650623996>



How might exposure to traumatic events impact on learning and cognitive performance?

List 5 impacts



Effects of trauma and refugee experience on psychological and neuropsychological presentation

There are many cognitive functions that underpin learning ability and the demonstration of that ability through performance.

- attention and concentration
- understanding instructions and input
- working memory, including the holding of information and instructions in the process of problem solving
- committing knowledge to long-term memory
- organisation of information and category formation
- shifting from the abstract to the concrete and back
- generating a range of strategies to a problem
- flexibility
- creative play
- anticipation of failure
- capacity for both emotional and behavioural self-regulation
- frustration tolerance and self-confidence

Effects of trauma and refugee experience on psychological and neuropsychological presentation

A child or adolescent of refugee background may have had little prior experience of cognitive skills relevant to performance on tests or classroom-based academic achievement.

Elliott, Lauchlan, and Stringer (1996) predicted that relatively new arrivals in the United Kingdom would be likely to experience significant difficulties in understanding test instructions.

Communication errors can occur when testing a child from a background where children are meant to listen and not speak. Answering an adult can violate norms of acceptable behaviour (Greenfield, 1997).

Effects of trauma and refugee experience on psychological and neuropsychological presentation

The experience of VFST staff, while working with children from East Timor during operation Safe Haven (VFST, 2000)

Children had little experience of using paper and pencils because of the unavailability of those materials in their country.

Many refugee children, more generally, would have little or no experience of drawing, manipulating blocks or working with time pressures (Hill, 2005).

Their parents may not be literate in their own language or they may come from an oral tradition in which characteristics of thinking are less linear and factual than those of written cultures (Ong, 2002).

Many refugee children and adolescents have been responsible for procuring food and essential material goods for their families, looking after younger siblings as well as habitually taking precautions against threats of violence.

Effects of trauma and refugee experience on psychological and neuropsychological presentation

Learning English as a second language

Migrant students learning English as an additional language in an English speaking country progress through five stages of acquisition, concluding at 5–7 years with advanced (or near native) fluency (Krashen & Terrell, 1983).

By this time, students are usually able to fully access the language of the curriculum in the classroom (Cummins, 1984).

Students from refugee backgrounds are unlikely to develop advanced fluency within 5–7 years due to disrupted language development on their refugee journey.

In fact, the process of understanding academic language can take 10 years to develop for those who have not had the opportunity to develop adequate first language skills (Thomas & Collier, 1997).



Effects of trauma and refugee experience on psychological and neuropsychological presentation

Poor concentration is one of the symptomatic criteria of PTSD

PTSD can affect both the learning of new information and cognitive skills, and the capacity to demonstrate this learning

Flashbacks, sleep disturbances including nightmares, conditioned reactions to reminders of the past, and re-enactments of past trauma – all severely interfere with **information processing** and a sense of inner stability (Streeck-Fischer & van der Kolk, 2000).

Children and adolescents with PTSD have problems with **attention, concentration, executive function skills and abstract reasoning** (Beers & de Bellis, 2002; Dunmore, Clark, & Ehlers, 2001; Pynoos, Steinberg, & Wraith, 1995; Toth & Cicchetti, 1998)

Effects of PTSD on psychological and neuropsychological presentation

Memory problems are frequently reported in the general population of individuals with PTSD and have been found to some degree in children and adolescent populations.

Children with PTSD show **lower scores in general memory, verbal memory, and learning**

When compared to a trauma only group, the PTSD group displayed **less effective and slower learning, was more susceptible to interference, and benefited less from using rehearsal**.

However, the children experiencing PTSD did not show impairment in short- and long-term recall when initial learning was controlled for; indicating that the problem was not in retrieval, but in encoding (Samuelson et al., 2010).

Effects of PTSD on psychological and neuropsychological presentation

Meesters, Merckelbach, Muris, and Wessel (2000) had noticed that their adolescent patients who had suffered abuse appeared to have **poor autobiographical memory**.

A person with PTSD will have trouble remembering to complete tasks and may have difficulty applying new information. In a classroom or work setting, this could be manifested by a person who fails to complete tasks and/or studying for examinations.

Effects of PTSD on psychological and neuropsychological presentation

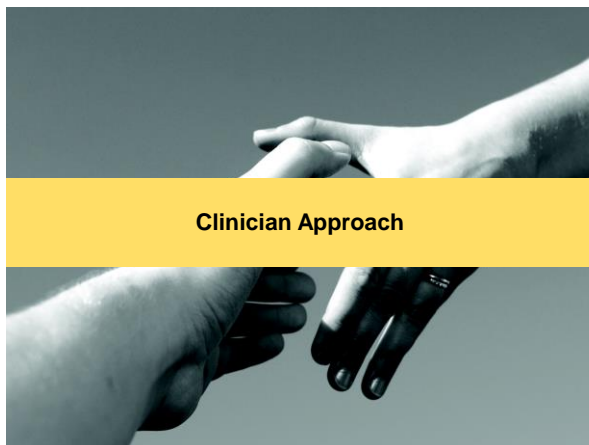
Children with PTSD were observed to display **heightened distractibility and difficulty with visual attention**. Scores on the Wisconsin Card Sorting Test (Grant & Berg, 1948) indicated that they have **trouble set shifting** as well as having **lower abstract reasoning and problem-solving skills**.

Attentional bias towards information related to trauma has been observed in adults with PTSD.

In a classroom or work environment, attentional problems could lead to easy distractibility that could lead to missing information and getting into trouble for not paying attention. The attentional lapses could then lead to poorer grades or work performance.

There is also the potential for misdiagnosing children with ADHD.

Clinician Approach



Clinician Approach

Professionals must be emotionally prepared to encounter trauma/torture experiences while remaining alert to any possibility that what they are hearing is evoking reactions in them that impair their work.

Pope and Garcia-Peltoniemi (1991) highlighted some of the common reactions of clinicians, including:

- an almost phobic reaction to the horrors endured by the torture victim, so that the clinician consciously or unconsciously attempts to avoid hearing the most painful aspects
- an almost voyeuristic or obsessive personal curiosity, resulting in the clinician pressing for and focusing on the most graphic details;
- a tendency to see the person solely as a "torture victim," with the label obscuring all personal or human characteristics that the clinician does not associate with a particular stereotype of torture victim;

Clinician Approach

- a tendency for the clinician's political beliefs or personal agenda to interfere with the ability to listen carefully and accurately to the person who has been tortured;
- a fear that the clinician may be at risk for negative consequences in some way from working with a torture survivor who is the target of widespread prejudice in the clinician's home country or who may still be hunted by those who perpetrated the torture
- some form of survivor guilt.

DIAGNOSTIC AND STATISTICAL MANUAL OF

Cultural Formulation Interview (CFI) from DSM-5

DSM-5

Cultural Formulation Interview (CFI) from DSM-5

Rationale:

Clinicians to be aware of relevant contextual information stemming from a patient's culture, race, ethnicity, religion or geographical origin.

For example, uncontrollable crying and headaches are symptoms of panic attacks in some cultures, while difficulty breathing may be the primary symptom in other cultures.

Understanding such distinctions will help clinicians more accurately diagnose problems as well as more effectively treat them.

The CFI provides an opportunity for individuals to define their distress in their own words and then relate this to how others, who may not share their culture, see their problems.

Cultural Formulation Interview (CFI) from DSM-5

A 16-question interview, with 12 supplementary modules:

- Explanatory Model
- Level of Functioning
- Psychosocial Stressors
- Social Network
- Cultural Identity
- Spirituality
- Religion, and Moral Traditions
- Coping and Help Seeking
- Patient-Clinician Relationship
- Immigrants and Refugees
- School-Age Children and Adolescents
- Older Adults
- Caregivers

Cultural Formulation Interview (CFI) from DSM-5

The CFI follows a person-centered approach to cultural assessment by eliciting information from the individual about his or her own views and those of others in his or her social network.

Designed to avoid stereotyping, in that each individual's cultural knowledge affects how he or she interprets illness experience and guides how he or she seeks help.

Because the CFI concerns the individual's personal views, there are no right or wrong answers to these questions.

Cultural Formulation Interview (CFI) from DSM-5

The CFI may be especially helpful when there is:

- Difficulty in diagnostic assessment owing to significant differences in the cultural, religious, or socioeconomic backgrounds of clinician and the individual
- Uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria
- Difficulty in judging illness severity or impairment
- Disagreement between the individual and clinician on the course of care
- Limited engagement in and adherence to treatment by the individual

Cultural Formulation Interview (CFI) from DSM-5

Systematic assessment of FIVE categories:

Cultural identity of the individual:

Describe the individual's racial, ethnic, or cultural reference groups that may influence his or her relationships with others, access to resources, and developmental and current challenges, conflicts, or predicaments.

For immigrants and racial or ethnic minorities, the degree and kinds of involvement with both the culture of origin and the host culture or majority culture should be noted separately.

Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and the need for an interpreter.

Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation.

Cultural Formulation Interview (CFI) from DSM-5

Cultural conceptualizations of distress:

Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others.

These constructs may include cultural syndromes, idioms of distress, and explanatory models or perceived causes.

The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural reference groups.

Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.

Cultural Formulation Interview (CFI) from DSM-5

Psychosocial stressors and cultural features of vulnerability and resilience:

Identify key stressors and supports in the individual's social environment (which may include both local and distant events) and the role of religion, family, and other social networks (e.g., friends, neighbors, coworkers) in providing emotional, instrumental, and informational support.

Social stressors and social supports vary with cultural interpretations of events, family structure, developmental tasks, and social context.

Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural reference groups.

Cultural Formulation Interview (CFI) from DSM-5

Cultural features of the relationship between the individual and the clinician:

Identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment.

Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter.

Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance.

Cultural Formulation Interview (CFI) from DSM-5

Overall cultural assessment:

Summarize the implications of the components of the cultural formulation identified in earlier sections of the Outline for diagnosis and other clinically relevant issues or problems as well as appropriate management and treatment intervention.

SUMMARY

Culture and Language can affect the way an individual presents (intellectually, psychologically, socially etc)

Remember to ask yourself:

- Does the word/information/meaning translate accurately?
- Is this important in their culture/environment/setting?
- Could their apparent "thinking difficulty" be better explained by culture, language differences or circumstance?

A "lower than average" cognitive profile does not necessarily mean poorer cognitive function

Neuropsychologists and professionals should take into account functional presentation and other evidence of skill (e.g. speed of learning a second language)

REVIEW!

Does the definition of intelligence differ between cultures? If so, how?

Western:

Eastern:

African:

ATSI Australian:

REVIEW!

List 5 ways that culture and education impact neuropsychological testing (or their cognitive profile)?

REVIEW!

List 5 ways that trauma and/or refugee experience can impact on a person's cognitive profile

REVIEW!

List 5 factors that impact on neuropsychological approach / cognitive assessment of ATSI Australians

REVIEW!

List 5 strategies professionals should use to be culturally and linguistically considerate

<http://www.culturalconversations.info/>